have been titled "Propranolol Withdrawal Complicating Bilateral Nephrectomy."

MARK C. HOUSTON, MD
*Assistant Professor of Medicine*
*Co-Director, Medical Intensive Care Unit*
*Vanderbilt Medical Center*
*Nashville, Tennessee*

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## Dr. Steinberg Replies

TO THE EDITOR: Dr. Houston's letter raises several important points that need clarification. Semantics are a problem in this field, but our report is not a simple case of hypertensive medication being stopped and restarted. In our patient, the cause of the hypertension, which was excessive renin from end-stage kidneys, was removed. Severe postoperative hypertension in a patient who is volume depleted by dialysis, who has no measurable renin and who still has a blood pressure of 270/120 mm of mercury, should not be confused with the more common rebound and overshoot hypertension that occurs when a patient simply stops taking his antihypertensive medication.

Although we are also familiar with the reports of severe high blood pressure when other drugs are suddenly discontinued, the cited references are not germane to our case. Dr. Houston is talking about rebound or overshoot hypertension and we described a singular circumstance in which severe and unremitting hypertension is related to catecholamines and drug withdrawal rather than a static state of sodium balance or the renin-angiotensin system. It was the uniqueness of this clinical setting of dialysis and bilateral nephrectomy that makes our remarks about clonidine and catecholamines justified. If the postoperative hypertension in this patient was not due to catecholamines or increased sympathetic discharge, what was it due to?

Finally, I doubt that our brief report could have been titled "Propranolol Withdrawal Complicating Bilateral Nephrectomy" as our patient was receiving propranolol after surgical operation and still required nitroprusside and phentolamine for acceptable blood pressure control to be achieved. This control was not accomplished until the seventh postoperative day when clonidine administration was reinstituted.

STEVEN M. STEINBERG, MD
*San Diego*